multicenter, prospective observational study was performed. Patients who met inclusion criteria were followed-up for a period of 12 months, with 3 visits programmed at baseline, 6 months and 12 months. a total of 9 Spanish hospitals were involved in the study. Questionnaires used to measure quality of life were: EQ-5D (generic questionnaire), Minessotta living with heart failure- MLWHF (specific questionnaire) and Barthel Index (index of independence). **RESULTS:** A total of 450 patients were included, 76% men, mean age was 62.6 years. 66.1% were in NYHA class II, 32.7% NYHA class III and 1.1% NYHA class IV. Prevalence of ischemic cardiopathy was 33.5%. 35% of patients had an implantable device (ICD, RCT or pacemaker). Significant differences were observed in Barthel Index's scores depending on class: class I 97.6 ± 6.7 vs. Class III-IV 91.8 ± 14.6. Related to EQ-5D tariffs, individuals in class II had a mean value of 0.8407 ± 0.1887 (out of 1), and mean VAS value of 60.6 ± 17.39 (out of 100). Individuals in NYHA class III or IV had a mean score of 0.6624 ± 0.2848, and mean VAS value of 51.93 ± 17.15 (out of 100). In a MLWHF questionnaire analyses, patients in NYHA class II showed a mean score of 32.52 ± 20.69 while patient in NYHA class III-IV showed a mean score of 50.44 ± 18.23. **CONCLUSIONS:** Our findings showed the results from the three questionnaires were generally consistent with each other and values reported from other countries in the literature.

PCV117

HEALTH-RELATED QUALITY OF LIFE IN PATIENTS WITH PULMONARY ARTERIAL HYPERTENSION

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OBJECTIVES: To characterize health-related quality of life (HRQoL) in patients with pulmonary arterial hypertension (PAH) in relation to persons of similar age and gender in the general United States (US) population. **METHODS:** Data were obtained from a large phase III clinical trial in which patients (n = 274) were randomized to sildenafil or placebo for 12 weeks. We characterized HRQoL using responses to the Short Form-36 General Health Survey (SF-36) obtained at baseline; the SF-36 addresses eight HRQoL domains: physical functioning (PF), role functioning–physical (RP), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), role functioning–emotional (RE), and mental health (MH). Values for these eight domains were then standardized to US population norms for persons aged 45–54 years (mean age of patients in trial was 49 years). **RESULTS:** A total of 39% and 58% of patients were designated at baseline as Functional Class (FC) II and III, respectively (<1% and 3% were designated as FC I and IV), with 75% women. Standardized mean scores were 30.4 for PF, 27.9 for RP, 47.8 for BP, 34.2 for GH, 41.2 for VT, 38.9 for SF, 34.9 for RE, and 43.7 for MH. In comparison with the US population, whose mean score for each domain = 50, PF, RP, GH, SF, and RE were all substantially worse for PAH patients. Additionally MH and VT were marginally worse among PAH patients, and BP was comparable to US norms. **CONCLUSIONS:** With the exception of bodily pain and mental health, PAH patients have substantially poorer SF-36 scores than their peers in the US general population, especially in terms of physical functioning, role functioning-physical, role functioning-emotional, and general health.

PCV118

TO DETERMINE THE EFFECT OF DIFFERENT DOSES OF POMEGRANATE ON BODY WEIGHT AND BLOOD PRESSURE

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OBJECTIVES: The aim of the present study was to evaluate the effect of 700 mg and 1400 mg pomegranate seed capsules on body weight and blood pressure for a period of 60 days at time interval 7, 14, 21, 28, 45 and 60 days respectively. **METHODS:** At the beginning of the study twenty four healthy human volunteers were selected. On the basis of BMI two broader groups, i.e. group 1 taking 700 mg pomegranate capsules and group 2 taking 1400 mg pomegranate capsules were designated and both the groups were subdivided on the basis of diet control and exercise i.e. group1 (IA, IB) and group 2(IIA, IIB). Group IA and IIA took pomegranate capsules without diet and exercise while IB and IIB took the capsules with diet and exercise. Hypertensive patients from these groups were included in both groups who were categorized and evaluated separately and compared with normal individuals. **RESULTS:** The result of investigation indicated that both doses of pomegranate seeds capsules had significantly reduced the body weight and blood pressure profile (both systolic and diastolic) in all groups when compared with their baseline values. However both doses caused equal reduction of body weight and blood pressure as no significant difference was present in both doses (p-value > 0.05). **CONCLUSIONS:** Thus on the basis of results obtained after conducting our study it was concluded that pomegranate seed capsules have established their efficacy and safety profile for obesity control and hypertension management.

PCV119

SURVEY AT RETAIL PHARMACIES LEVEL ASSESSING QUALITY OF LIFE OF VKAS PATIENTS

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OBJECTIVES: To measure how VKA's patients assess their treatment in terms of medication intake constraints, monitoring and psychological impact related to perceived risk. **METHODS:** Questionnaires to patients under VKAs for at least 3 months. Questionnaires were distributed through 150 retail pharmacies spread over all France from November 2009 to March 2010. a random distribution of questionnaire was made. **RESULTS:** 1094 questionnaires were administered. Study included 58% men and 42% women aged >65 years for 72%; patients aged more than 75 years represented 43%. Patients were treated in majority by fluindione (82.3%) and for more than 3 years (65.1%). Patients were treated in majority for cardiac rhythm disorder (40%). More than ¾ (77%) of VKAs patients consider their treatment being a burden even though being vital. Treatment is judged as being a constraint because of the obligation to adapt dosages according to coagulation monitoring (42%), and due to the necessity to contact their physician after each blood sample (25%). The requirement to permanently have a monitoring is considered as constantly reminding the associated risk (65%), expectation of coagulation monitoring results generate anxiety for more than ¼ of patients (27%). Majority of patients acknowledge that regular blood sampling is a constraint (53%) and that the treatment would be more convenient without these constant blood samplings (60%). In parallel, 38% of patients interviewed consider that the VKA treatment constraint is reinforced by the fact that they cannot eat what they would like. Patient preference for a new treatment is in priority: a treatment without regular blood sampling (62%); a treatment for which the daily anticoagulant dosage does not need adaptation (60%). **CONCLUSIONS:** Treatment by VKAs is perceived as burdensome and risky by a majority of patients due to the constant monitoring required and the uncertainty of the good blood dosage.

CARDIOVASCULAR DISORDERS – Health Care Use & Policy Studies

PCV120

COMBINED MEDICATION CHOICE AND PATIENT PERSISTENCE IN HYPERTENSION THERAPY: EVIDENCE OF REAL-LIFE EFFECTIVENESS

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OBJECTIVES: While hypertension treatment guidelines emphasize the medical benefits of combined medication choice, consumption patterns of antihypertensive drugs raise worldwide several questions related to real-life therapeutic and cost-effectiveness. Hungary has a relatively poor track record: international comparative studies show Hungarian patients' adherence to treatment to fall behind not only desirable targets but also international average values. In our analysis, we start from the hypothesis that medical benefits achievable through combined therapy are weakened through inadequate patient adherence, and we investigate into the health loss caused to Hungarian patients by insufficient persistence in combined hypertension therapy. Our goal is to determine how the real-life consumption patterns of combination hypertension therapy impact real-life therapeutic effectiveness and cost-effectiveness. **METHODS:** We use itemized prescription-level data from the Hungarian National Health Insurance Fund Administration's (NHIFA) database. Our research covers patients whose therapy was initiated during 2008 or 2009 with high-value fix-dosage (one-pill) and non-fix-dosage (multiple-pill) angiotensin-converting enzyme inhibitor (ACEI) and calcium channel blocker (CCB) combinations, or angiotensin-receptor blocker (ARB) and CCB combinations. **RESULTS:** Adherence to treatment is measured as persistence on the initiating combination therapy. Firstly, 'hard' persistence (which does not allow for add-on therapies) and 'add-on' persistence (which allows for additional active substances being added to the therapy regime) are separately calculated, both for fix-dosage and non-fix-dosage combinations. Secondly, if the initiating therapy is a fix-dosage combination, parallel consumption of monocomponents is also analyzed. Thirdly, we carry out a switch analysis to determine the active substances that patients had been taking before receiving a fix-dosage combination, or take after abandoning the fix dosage combined therapy. **CONCLUSIONS:** We hypothesize that substantial societal loss is caused by patient non-adherence in hypertension treatment and clinical advantages of combination therapies are significantly impaired. Our research will deliver exact calculations for the extent of the societal loss.

PCV121

A SURVEY OF PHYSICIANS' ATTITUDES TOWARD THE CONTROL OF CARDIOVASCULAR RISK FACTORS. THE EURIKA STUDY.

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OBJECTIVES: Cardiovascular risk factors remain poorly controlled across Europe despite clinical guidelines. The European Study on Cardiovascular Risk Prevention and Management in Daily Practice (EURIKA) investigated the use of cardiovascular risk assessments tools and guidelines, and explored factors limiting their use. **METHODS:** Physicians (n = 806) from 12 European countries answered questions regarding their work setting, their assessment of patients with cardiovascular risk factors, and their use of risk calculation tools and clinical guidelines. **RESULTS:** Participating physicians worked in primary care centres or outpatient clinics; 63.8% were GPs. The majority (69.3%) reported using global risk calculation tools. Written charts were the preferred method (69.9%), followed by software (33.0%). The most popular tools were SCORE (European Society of Cardiology [ESC]; 52.4%),